



Date of Transport: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Weight (&gt;200lbs): \_\_\_\_\_

Requesting Facility: \_\_\_\_\_ Floor/Room: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_

Requesting Physician: \_\_\_\_\_

Receiving Facility: \_\_\_\_\_ Floor/Room: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_

Receiving Physician: \_\_\_\_\_

Diagnosis or Reason for Transport: \_\_\_\_\_

Airway: Oxygen (LPM): \_\_\_\_\_ CPAP: \_\_\_\_\_ Nebs: \_\_\_\_\_

IV/PCA Therapy: Yes / No Solution: \_\_\_\_\_

Insurance Information: 1) \_\_\_\_\_

2) \_\_\_\_\_

Please include: Prescription Form indicating Reason for Transport and Face Sheet with Patient

**Hospital-to-Hospital or ICU/ER Transfers - Please complete the following:**

Patient Category:

Trauma: Mechanism of Injury: \_\_\_\_\_

Intubated: Y/ N Chest Tube: Y/N NG: Y/N Long Board: Y/N C-Collar Y/N

Cardiac: Chest pain: Y / N If No, Pain free how long? \_\_\_\_\_ History: \_\_\_\_\_

Enzymes: Troponin: \_\_\_\_\_ CK: \_\_\_\_\_ CK-MB: \_\_\_\_\_

12 Lead EKG: \_\_\_\_\_

Medical: \_\_\_\_\_

Surgical: \_\_\_\_\_

Burn: \_\_\_\_\_ % \_\_\_\_\_

Pediatric: \_\_\_\_\_

Obstetric: Gravida: \_\_\_\_\_ Para: \_\_\_\_\_ Contractions: Y / N Min apart: \_\_\_\_\_

ROM: Y / N Bleeding: Y / N MD With: Y / N

Other: \_\_\_\_\_

Equipment Needed: \_\_\_\_\_

(IV Pump, Oxygen, Ventilator, Cardiac Monitor, Balloon Pump, VAD, Etc.)

IV Therapy: Type/Number of IV: Peripheral \_\_\_\_\_ Swan \_\_\_\_\_ Central \_\_\_\_\_ Art Line \_\_\_\_\_ IO \_\_\_\_\_

Medications Infusing: \_\_\_\_\_

Rate: \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_

Blood products Infusing: Y / N Additional To Be Hung Enroute: Y / N

Medications Administered or Needed During Transport: \_\_\_\_\_